Part Time Faculty
Medical Re-Enrollment

West Valley-Mission
Community College District

I request to continue my enrollment in medical coverage, and I certify the following by checking these boxes:

☐ I confirm that an employer other than a California community college district is not paying health insurance premiums for me or my enrolled dependents during the Coverage Period

Fall Coverage Period: November through April
Spring Coverage Period: May through October

☐ I understand that as a result of beginning a new eligibility period I may change my medical plan by submitting a completed CalPERS HBD-12 enrollment form

☐ I understand that if I wish to waive coverage I must submit a completed CalPERS HBD-12 waiver form

I understand that if I am no longer receiving a paycheck from the District during the coverage period, I am responsible for paying the employee portion of my health benefits to the District. I understand that failure to make payments may result in termination of coverage.

Print Name WVMCCD-G#

Coverage Level:

Employee Only ☐ Employee+1 ☐ Family ☐

Health Plan Name

Signature Date

Email your signed and completed form to: melissa.duran@wvm.edu